



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: VISTA HEALTHCARE INC 4301 VISTA RD PASADENA TX 77504-2117	MFDR Tracking #: M4-03-0839-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Transcontinental Insurance Co. Box #: 47	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Vista Healthcare charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by Vista Healthcare is at a minimum of 70% of billed charges. This is supported by a managed care contract... that is attached as Exhibit 1."

Amount in Dispute: \$12,025.31

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier's rate of reimbursement in this case not only meets but exceeds the Act's criteria for payment in all respects. Provider has the burden of proof in this case. The provider has simply not met its burden of proof under rule 133.305(e)(1)(F) to establish that its billed charges of \$13,428.53 meet the statutory standards under the Act for reimbursement of facility charges for a knee arthroscopy. On the contrary, this amount is grossly excessive as established by the Commission's inpatient surgical per diem rate; the Medicare rate; the payment rate established by the workers' compensation authorities in Nevada, Massachusetts, and Pennsylvania; the anticipated rate under the ASC fee guideline being drafted by the Commission; and finally, the rate determined by SOAH to be fair and reasonable in prior ASC disputes. For these reasons, Provider has not met its burden of proof to establish that its charges comply with the Act's statutory standards for reimbursement and that Carrier's rate of payment does not. Therefore, Provider is not entitled to additional reimbursement."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
11/6/2001	F	Outpatient Surgery	\$12,025.31	\$0.00
			Total Due:	\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective October 7, 1991 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on October 2, 2002. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 2, 2002, 26 TexReg 10934, applicable to disputes filed on or after January 1, 2002, the Division notified the requestor on October 11, 2002 to send additional documentation relevant to the fee dispute as set forth in the rule.

- For the services involved in this dispute, the respondent reduced or denied payment with reason code:
 - F – Reduction According to Fee Guidelines
- This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the

provisions of Division rule at 28 TAC §134.1(f) effective October 7, 1991, 16 TexReg 5210, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b) [currently Texas Labor Code §413.011(d)], until such period that specific fee guidelines are established by the commission.

3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Division rule at 28 TAC §133.307(e)(1)(B), effective January 2, 2002, 26 TexReg 10934, applicable to disputes filed on or after January 1, 2002, requires that the request shall include "a copy of each explanation of benefits (EOB)... relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB." Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of the EOB detailing the insurance carrier's response to the request for reconsideration. Neither has the requestor submitted convincing evidence of carrier receipt of the provider request for an EOB. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(e)(1)(B).
5. Division rule at 28 TAC §133.307(g)(3)(B), effective January 2, 2002, 26 TexReg 10934, applicable to disputes filed on or after January 1, 2002, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the documentation submitted by the requestor finds that the requestor has not provided medical records to support the services in dispute. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(B).
6. Division rule at 28 TAC §133.307(g)(3)(D), effective January 2, 2002, 26 TexReg 10934, applicable to disputes filed on or after January 1, 2002, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
 - The requestor asks in the position statement to be reimbursed for the full amount of the billed charges in support of which the requestor states "Vista Healthcare charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services."
 - The requestor further states that "...Vista Healthcare, Inc. made an extensive review of payments and reimbursements made by various Carriers from the geographical area of Texas for treatment, services and supplies utilized for both work-related and non-work related injuries. As a result of that review, Vista Healthcare, Inc. was able to determine the usual amounts reimbursed by carriers for treatment, services and supplies from Vista Healthcare, Inc. for both work-related and non-work related treatment in the state of Texas at their facility."
 - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
 - Documentation of the comparison of charges to other carriers was not presented for review.
 - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
 - Documentation of the extensive review of payments and reimbursements made by various carriers from the geographical area of Texas was not submitted for consideration in this review.
 - The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former Acute Care Inpatient Hospital Fee Guideline, 22 TexReg 6276 (July 4, 1997). It further states that "Alternative methods of reimbursement were considered... and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges..." 22 TexReg 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
 - In the alternative, the requestor asks to be reimbursed a minimum of 70% of billed charges, in support of which the requestor states that "This is supported by a managed care contract... that is attached as Exhibit 1. This managed care contract supports Vista Healthcare's argument that the usual and customary charges are fair and reasonable and at the very least, 70% of the usual and customary charges is fair and reasonable." The requestor further asserts that "...the managed care contract shows numerous Insurance Carrier's [sic] willingness to provide 70% reimbursement for Ambulatory Surgical Centers medical services."
 - Texas Government Code § 2001.081 states that "The rules of evidence as applied in a nonjury civil case in a district court of this state shall apply to a contested case..." The Texas Rules of Evidence, Rule 1002 requires that "To prove the content of a writing, recording, or photograph, the original writing, recording, or photograph is required except as otherwise provided in these rules or by law." Review of the requestor's documentation finds that the

requestor did not submit a copy of the alleged contract for consideration, nor did the requestor demonstrate that any exception to this requirement applies to the documentation in this dispute.

- The requestor has provided select exhibit pages from the alleged managed care contract referenced above, however no copy of the contract referenced in the position statement was presented for review with this dispute.
- Review of the exhibit pages submitted by the carrier finds that the fee schedule page (labeled exhibit A) dated effective August 1, 1992 states, in part, that the provider shall receive “an amount equal to eighty percent (80%) of the Usual and Reasonable Charge for those Covered Services.” It goes on to define the Usual and Reasonable Charge as “equal to the lesser of: (i) the actual charges billed by HCP for such services; or (ii) the eightieth (80th) percentile for charges for such services as set forth in the current Medical Data Research database.”
- No data or information was submitted from the Medical Data Research database to support the requested reimbursement.
- The requestor also presented a separate schedule of charges (also labeled exhibit “A”) dated 04/23/92, which states that “OUTPATIENT SERVICES: 101/401 PAY 70% OF BILLED CHARGES.” However, this exhibit page is dated before the August 1, 1992 exhibit page referenced above, which specifies a different reimbursement amount.
- No evidence was presented by the requestor to support that the referenced contract was in effect at the time of the disputed services.
- The requestor’s position statement further asserts that “amounts paid to healthcare providers by third party payers are relevant to determining fair and reasonable workers’ compensation reimbursement. Further, TWCC stated specifically that managed care contracts are fulfill [sic] the requirements of Texas Labor Code Section 413.011 as they are ‘relevant to what fair and reasonable reimbursement is,’ they are relevant to achieving cost control,’ they are relevant to ensuring access to quality care,’ and they are ‘highly reliable.’ See 22 TexReg 6272. Finally, managed care contracts were determined by the TWCC to be the best indication of a market price voluntarily negotiated for medical services...”
- While managed care contracts are relevant to determining a fair and reasonable reimbursement, the Division has previously found that a reimbursement methodology based on hospital costs does not produce a fair and reasonable reimbursement amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:
“The Commission [now the Division] chose not to adopt a cost-based reimbursement methodology. The cost calculation on which cost-based models... are derived typically use hospital charges as a basis. Each hospital determines its own charges. In addition, a hospital’s charges cannot be verified as a valid indicator of its costs... Therefore, under a so-called cost-based system a hospital can independently affect its reimbursement without its costs being verified. The cost-based methodology is therefore questionable and difficult to utilize considering the statutory objective of achieving effective medical cost control and the standard not to pay more than for similar treatment to an injured individual of an equivalent standard of living contained in Texas Labor Code §413.011. There is little incentive in this type of cost-based methodology for hospitals to contain medical costs.”
- The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

7. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(e)(1)(B), §133.307(g)(3)(B), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature

Grayson Richardson

Medical Fee Dispute Resolution Officer

December 14, 2010

Date

Authorized Signature

Medical Fee Dispute Resolution Manager

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.